Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS213AGC	A. BUILDING _____ B. WING _____	C 12/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD REST HOME 3	4140 E CINCINNATI AVE LAS VEGAS, NV 89104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 12/14/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was six. Six resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A.	Y 000		
Y 026 SS=D	449.190(3) Contents of License-Multiple Types NAC 449.190 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services. This Regulation is not met as evidenced by: Based on observation, record review and interview on 12/14/10, the facility was caring for 1	Y 026		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 026	Continued From page 1 of 6 persons with chronic illnesses without an endorsement and failed to obtain the necessary training to care for such persons (Resident #3). Severity: 2 Scope: 1	Y 026		